DOCUMENT RESUME

ED 475 589 CG 032 354

AUTHOR	Oxman, Elaine B.; Chambliss, Catherine
TITLE	Reinvigorating Inpatient Group Psychotherapy: Integrating Clients' Off-Unit Experiences in Treatment.
PUB DATE	2003-00-00
NOTE	12p.
PUB TYPE	Reports - Research (143)
EDRS PRICE	EDRS Price MF01/PC01 Plus Postage.
DESCRIPTORS	Counseling Effectiveness; *Counseling Techniques; Evaluation Methods; *Group Therapy; Individual Needs; *Outcomes of Treatment; Patients; *Psychiatric Hospitals; *Psychotherapy

ABSTRACT

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Reinvigorating Inpatient Group Psychotherapy: Integrating Clients' Off-Unit Experiences in Treatment

by

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Reinvigorating Inpatient Group Psychotherapy: Integrating Clients' Off-Unit Experiences in Treatment

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Abstract

Publicly funded psychiatric inpatient institutions focus increasingly on stabilization and relapse prevention, readying patients for rapid community reentry. Growing emphasis on consumer satisfaction and professionals' accountability for efficient outcomes has coincided with increasing cost concerns. Since staffing limitations mandate innovative use of group methods, psychotherapists must develop engaging, instructive programs that reach heterogeneous groups of patients and yield measurable outcomes. Maintaining clients' focus on community reentry by using the group therapy setting to showcase their off-unit successes was found to increase group attendance, participation, and reports of perceived efficacy among group members. Several strategies for integrating such experiences within a cost-effective group context will be presented.

Introduction

Emphasis on stabilization and rapid discharge have refocused the energies of most group psychotherapists in large psychiatric institutions. Discussions aimed at enhancing coping skills and self management strategies have supplanted historical forays into the hypothetical origins of problem behavior. Insight into one's need for maintenance medications is often seen as the insight that matters most. More and more clinicians make use of a solution-focused approach, which emphasizes clients' strengths and episodes that represent exceptions to their problematic responding.

Today's inpatient psychiatric facility has been much changed by managed care. Shorter stays and keen focus on rapid stabilization through medication have reduced hospital units' ability to provide a sanctuary from life stressors. Instead, rapid patient turnover and heterogeneous patient grouping impose stresses of their own on patients' lives. There is usually only time to diagnose and treat; development of optimal grouping of patients based on particular needs is a luxury no longer possible.

Now, hospitalization entails enrollment in a crash course on coping with human diversity at its most extreme. Patients must learn to handle recurrent hostile outbursts, psychotic accusations, and sadistic verbal threats, all while struggling to cope with their own inner demons. The distraction that the pathos of others provides may arguably be somewhat therapeutic, and the lessons of patience, tolerance, and artful dodging learned may be usefully generalized to their patients' lives following discharge. However, the exposure to acute pathological behavior in an understaffed context, where the time constraints often preclude development of supportive bonds among patients, can also be extraordinarily depleting. Drained, people overreact to slights, and the problems, escalate; the cycle of despair continues and the struggles are aggravated.

The challenge to therapists is to counter this demoralizing reality through all means possible. Group techniques aimed at rapidly encouraging social support and validation are helpful. Strategies for deescalating tense situations can be shared and practiced. The need for psychotherapists on these units is keener than ever.

As a result of ongoing reductions in staffing complements in publicly funded inpatient hospitals, psychologists are increasingly encouraged to provide group psychotherapy rather than individual therapy. Given the pressures to (1) maintain high levels of consumer satisfaction, (2) provide rapid stabilization of functioning and effective relapse prevention interventions, and (3) include all patients in active treatment, therapists are compelled to experiment with innovative ways of using group psychotherapy methods. Augmenting these already daunting challenges are changes in modal patient characteristics. Patients present increasingly severe and persistent problems in inpatient treatment settings. Thanks in part to managed behavioral healthcare systems, hospitalization is the treatment of last resort, increasingly reserved for cases involving extremely volatile and potentially dangerous behaviors, where risk of symptom exacerbation during the course of treatment is high (Chambliss, 2000).

Addressing these challenges requires innovative applications of traditional interventions (including social skills training, supportive reflection, and cognitive behavioral techniques) and newer therapeutic approaches (including solution focused methods, pharmacotherapy education, and cognitive engagement techniques). Variable levels of patient functioning often make it difficult to engage all members of groups in collaborative activities. High demands for attention on the part of some group members can prove disruptive to the group experience. Special group strategies are needed to simultaneously meet the needs of active patients requiring a great deal of redirection, the needs of passive, fearful, and withdrawing patients who need to be coaxed to participate, and the needs of eager patients seeking positive shared group experiences.

Because of rapid patient turnover, it is generally unfeasible to develop and maintain groups of similarly diagnosed patients in today's treatment settings. Although empirically supported treatment methods must be provided, it is rare to encounter groups whose members all share the same diagnosis and co-diagnoses. Group composition shifts from week to week, making it necessary to use a modular approach to treatment that does not require continuity which can not be guaranteed. These various realities help to make delivering group psychotherapy in these inpatient contexts both exciting and stimulating; no two weeks are ever the same, and creative flexibility is always necessary.

One of the most significant drawbacks of inpatient care involves its isolation of clients

from opportunities to experience outside social, occupational, and educational successes. All too often, hospitalization transforms a client's identity by emphasizing pathological behavior (Chambliss, 1988; Chambliss, 2000). The challenge for group therapists is to strengthen existing client competencies in a context that threatens to reinforce passivity and negative attention-seeking behaviors. While various positive behaviors occurring spontaneously in the unit residence provide regular opportunities for group leaders to highlight clients' achievements, interviews with patients revealed that many felt most proud of accomplishments while on pass or while involved in various formal off-unit activities.

In order to build upon this pride and to emphasize the patients' successful functioning away from the formal treatment unit, the decision was made to make discussions of outside successes a consistent part of group therapy meetings. More systematic integration of such off-unit experiences was also expected to increase generalization of treatment gains, by increasing perceived self efficacy and emphasizing skill performance off the unit. Since most clients were already being encouraged by their treatment teams to participate in various off-unit experiences (offered as part of a treatment mall program, a supervised workshop program, a consumer center, and a greenhouse patient worker program), it was possible to revise group meetings with the explicit purpose of building on clients' off-unit success experiences. In order to achieve this objective, several group interventions aimed at systematically integrating off-unit experiences were evaluated.

Innovative means of tailoring group meetings to address widely varying patient needs, and to supply various specific treatment interventions are crucial for these treatment settings. This study involved a preliminary assessment of several group techniques designed to integrate patients' off-unit experiences with their more traditional therapy experience on the unit. The goal was to offer more energizing, positive, individualized treatment experiences within a cost-effective group format. The methods evaluated allowed the therapists to enhance the generalization of group therapy experiences to settings beyond the unit, as well as to encourage involvement in various work and training opportunities by offering explicit reinforcement for these activities in the group therapy setting. This attempt to integrate various elements of care was intended to tailor the treatment experience more closely to the specific needs of individual inpatients, while increasing the efficiency of the treatment process. Several strategies for integrating off-unit experiences will be reviewed.

Group Strategies for Integrating Off-unit Experiences

One tactic for integrating off-unit experiences involves structuring a brief reports period at the start of group sessions. During this period, "good news" is solicited from all group members, and specific inquiries are made about participation in available off-unit activities of various types, including both employment and special training experiences.

Providing brief reports of their experiences with parttime employment allows members the opportunity to receive recognition for their accomplishments, and to learn about available options open to those in treatment. The group discussions that result challenge negative stereotypes about those suffering from mental illnesses, by providing irrefutable evidence that many of those with severe illnesses can function quite capably in a variety of settings. This

information about peers often transforms relationships among residents, helping them to see each others' strengths, and to appreciate the potential resource provided by their collective experience with life and treatment.

Providing brief reports about various ancillary treatment experiences informs all group members about available training options, increases motivation to participate in future weeks, and allows for consolidation of new learning by giving patients the opportunity to describe what they learned and how they are beginning to put this to practice. This serves to amplify the impact of available off-unit treatment experiences. For example, a patient participating in a special computer skills course can use the group forum to explain how to use a mouse and menus to all members, including those who are still too intimidated by technology to attend such training. This can help to desensitize group members who were previously afraid to engage in such training, while giving the "teacher" the chance to rehearse their skills and gain respect for taking the risk to undertake this new challenge.

Since patient attendance started fairly high and gradually increased as the tone of meetings became more positive and mutual cheerleading became more the norm, it was important to ensure that all attendees had the opportunity to participate. Use of a simple, structured, brief "mood check" (Are you having a good day, neutral day, or rough day?) with all patients alerted the leader to particularly demanding crises and afforded all members the opportunity to voice concerns. After attending to any pressing "new business", efforts were made to systematically explore for instances of off-unit successes. Inquiries about treatment mall experiences in the previous week (Which modules did you sign up for? How did you do?) and questions about employment experiences were used to solicit discussion about off-site experiences. Members were also asked if home visits and other off-unit experiences had provided them with any opportunities to practice some of the coping strategies they had discussed during previous group meetings. Explicitly tying group content to applied settings beyond the formal treatment setting helped patients see the relevance of their treatment experiences. It also seemed to maintain their focus on discharge planning, rather than on acclimating to the hospital environment and focusing on settling into comfortable relationships with peers.

Another strategy used in this study involves a means of offering members, on a rotating basis, to be "Star for a Day" with certain group meetings. This strategy makes one individual the special focus of part of the group session, and provides them with the opportunity to reflect on their recent and past successes, and to discuss how the various elements of their treatment experience (both on-unit and off-unit) are contributing to their achievement of treatment objectives. We often develop various programs with a clear rationale in mind, but often patients are unaware of the consequences we intend their efforts to have. By helping patients to see that acquiring and practicing basic employment skills we are hoping to help them eventually locate and obtain a parttime job, therapists can help sustain their motivation to participate in sheltered workshop and other supervising work settings. Explaining that the objective of employment may be as much intended to provide structure and socialization opportunities for them as it is intended to address financial concerns can help to reduce some patients' resistance to the idea of working. Some hospitalized patients feel that it is unfair to expect them to hold down a job, even a parttime one, because of the burdens imposed by their illnesses. Helping them see that finding the right type of parttime work may be in their best psychological interest can help increase the

likelihood of their staying engaged in relevant training programs.

When the "Star for a Day" tactic is used, the individual occupying this special role alternates, so that over several weeks' time, every member gets the opportunity to receive this focused attention. The patient selected is asked to suggest a particular concern, area of need, or individual treatment objective. Other members serve as therapeutic assistants in helping the leader develop strategies for addressing the individual patient's specific needs.

A third strategy, Peer Mentoring, extends the use of peers beyond the formal group meeting period. Part of the group time is used to plan and structure supportive learning activities for dyads of patients to share in between formal group meetings. Progress in initiating and pursuing these planned activities is assessed at the beginning of each group meeting.

A fourth strategy involves use of Goal Groups, which permit patients to discuss what they need to do while in the hospital in order to facilitate discharge. The psychologist can praise patients who show even minimal progress, and can structure the discussion to encourage mutual support of appropriate behavior. The common goal of discharge unites all members, while the individual obstacles to this goal are being addressed. Specific opportunities to addres how off-unit experiences can contribute to the achievement of common goals can help to increase individual patients' motivation, and can also foster the creation of mutually supportive groups of patients who choose to get involves together in common off-unit activities.

A fifth strategy, particularly important in very large groups, is to make use of interdisciplinary interventions within group meetings. Incorporation of music, art, dance, exercise, budgeting, and cooking activities can help maintain patients' enthusiasm for the large group experience. Providing positive experiences that stimulate various sensory modalities can increase subsequent engagement in more traditional problem solving discussions. In addition, learning how to make positive use of leisure time is important to these patients' eventual discharge success.

Method

Sixty-five inpatients from three units of a 600-bed state psychiatric institution participated weekly in both large (n=14-18 patient members) psychotherapy groups revised to accommodate enhanced individualization of psychotherapy and small (n=3-7 patient members) psychotherapy groups. Over the course of a 6 month trial period that began with a hospital-wide adoption of universal off-unit training experiences for all ambulatory patients, three anonymous patient surveys were conducted at roughly 3-month intervals in order to assess patient satisfaction with several strategies being used to integrate group therapy activities with the new off-unit experiences being promoted. Baseline measures of patient satisfaction with the group treatment program were obtained before the new strategies were implemented. Patient satisfaction was assessed at 3 -month intervals after the techniques had been introduced. Measures of patient behavior within the group program were also collected. Measures of problem behavior episodes on the treatment unit were obtained for both a 6-month pretreatment and a 6-month posttreatment period. Pre and posttreatment comparisons were used to assess the behavioral impact of these attempts to tailor treatment more systematically.

On one of the three inpatient units, each week patients were given a choice of whether to

participate in the large (n=14-18 patient members) psychotherapy group or the small (n=3-7 patient members) psychotherapy group. Patients were encouraged to assess their current need for individualized attention and willingness to talk within the group, and to select the group size that best suited their needs that day. Patients were thereby enabled to tailor their own treatment experience, based on their fluctuating preferences.

On two of the three wards, there were insufficient staff members to permit patients a choice of group size. Most groups were large (14 to 15 members) and included patients who differ in regard to cognitive skills/deficits, psychotic manifestations, and stability/instability of symptoms. Many of the patients have short attention spans and would not be willing or able to engage in complex discussions.

The large group experience included regular use of the Brief Reports period at the beginning of group sessions, and periodic use of the "Star for a Day" strategy, which makes one individual the special focus of part of the group session. Peer Mentoring was also used to enhance the effectiveness of the very large group sessions. It encourages the development of mutually supportive patient dyads, to extend the work of the group beyond formal meeting times, and to provide practice in maintaining positive social bonds.

In each patient's treatment plan, the basis for all activities on the ward, there are listed short-term objectives that the patient is supposed to accomplish as steps toward a long-term goal. The goal in each case is based on controlling the problem that caused the present hospitalization. Many of the patients were hospitalized because their behavior made them unacceptable to the group homes in which they had lived. Goal Group sessions were used to permit patients to discuss what they need to do while in the hospital in order to facilitate discharge. The objectives in these cases might involve accepting reality-based feedback from staff demonstrating appropriate social interaction with peers. Some patients have difficulty in focusing attention long enough to handle the ordinary personal and interpersonal activities of daily life. The objectives in these cases might involve focusing attention long enough to proceed with a task or topic for a certain period of time (e.g. five minutes).

In order to provide a positive experience for each patient, and to work toward accomplishing the objectives, the therapist needs to be flexible and creative in choosing programs, presenting topics and tasks, and encouraging appropriate interactions. Often it has proved valuable to utilize the services of therapists from more than one department, to give patients a variety of experiences within a group.

Results

Measures of patient satisfaction showed that group members responded positively to the intentional attempts to integrate off-unit experiences within the group therapy sessions. Patients enjoyed being provided with opportunities to review their recent off-unit experiences together, said they felt that they learned valuable information when listening to others give reports, and reported greater enthusiasm for future off-unit experiences after participating in groups with this new emphasis. The level of members' participation in various off-unit activities (both employment and special training) increased among those who regularly attended group meetings designed to integrate these experiences.

Attendance at group meetings improved following incorporation of these techniques for integrating off-unit experiences. During the 6 month trial period, there was considerable rotation of patients between the small and large groups. This suggests that patients did try to match the therapeutic experience to their particular needs on that particular day. When asked about factors influencing patients' group size choices, several patients said that they knew that on some days they needed to talk a lot and would have difficulty being patient with the frustration of waiting for their turn in the large group. The fact that the small group reduced the frustration experienced by patients when they were "having a bad day" may have contributed to some reduction in the number of self-injurious and assaultive behavioral episodes from the pre-treatment to post-treatment periods.

One of the unforeseen advantages of the use of dual group delivery was that it seemed to help curb symptom contagion. When one patient began behaving in a recurrently self injurious manner, she was encouraged to select the small group, and only patients with little risk of imitating her choices were encouraged to attend the small group during this period. In the past, when such patients were integrated into larger groups, their apparent success in obtaining special attention from staff often contributed to a rash of similar acting out on the part of other patients. Pairing a small and extra large group, rather than using two medium sized groups, seemed to reduce this risk.

The strategies that were used to modify the large group meetings succeeded in providing needed social stimulation for both low-functioning and high-functioning patients, and gave patients many opportunities for guided interactions. Patient attendance and participation rates improved after implementation of new techniques aimed at enhancing patient engagement. The majority of the patients could remember at least some of the words and music of songs they had learned as children or adolescents, and could join in singing familiar numbers. After each song, the psychologist encouraged reminiscences and then led a group discussion that often involved the content of the song as well as memories associated with it.

This program was satisfying to the participants and led to progress toward the patients' treatment objectives. High-functioning patients were helped to provide assistance to their lower-functioning peers, who in turn expressed satisfaction about what they had been able to remember. Outside of formal group meetings, the peer mentoring approach resulted in the creation of several mutually supportive patient dyads (for example, one woman skilled at piano paired up with another graced with a lovely voice to enter a local talent show; a patient newly diagnosed with diabetes was taught the basis of glucose testing by another group member).

Discussion

These findings suggest that choices that therapists make within traditional group therapy sessions ca have a significant impact on patients' participation in off-unit activities. It also supported the notion that group meetings can enhance the benefits associated with these off-unit opportunities.

Not surprisingly, this approach seemed to be more effective with patients drawn from an active unit populated by young individuals (mean age of 36 years) than with a unit of more geriatric individuals needing greater nursing care. The older patients reported success

experiences with treatment mall activities involving music activities and discussions and interactions with pets, but were less apparently satisfied with other educational modules being provided. The younger patients gravitated to relaxation and leisure modules, budgeting training, and various other educational programs provided off-unit.

Use of some group therapy time to supplement these off-unit experiences seemed to have discernible reciprocal effects. Interest in attending and participating in psychotherapy group meetings increased, and patients' level of involvement in off-unit experiences also went up. The groups' social reinforcement of successful engagement in activities off the unit provided support for patients' venturing beyond their secure, familiar setting, building their confidence and willingness to take appropriate risks. Although no measures of discharge planning efficiency were taken (in part because this process is powerfully constrained by available community placement resources), it seemed that patients who participated in groups with this new emphasis on off-unit accomplishments were more cooperative in fashioning realistic discharge plans. This may be because their increased sense of self efficacy contributed to reduced ambivalence about being discharged, although verifying this assumption will require further study.

In addition, the experiences of group members during this period of observation offered further support to previous findings about the advisability of offering patients control over the nature of their group therapy experiences. As has been found in earlier assessments, offering patients the opportunity to select the size of therapy group permits many the chance to gauge their immediate needs and abilities to handle the stress of social situations, and to match their treatment experience accordingly.

Offering group techniques designed to enhance off-unit treatment experiences, and flexible group experiences (either patient-selected group size, or large group modifications) may be a practical way of improving treatment delivery while working within budgetary constraints. The patients seemed to welcome the efforts made to address their individual treatment needs more systematically. However, several factors limit the conclusions that may be drawn here. First, although those who attended group sessions designed to integrate off-unit experiences increased their level of engagement in such pursuits during the course of the 6-month assessment period, it may be that those individuals were more highly motivated to begin with. It seems quite possible that their decision to attend many therapy group meetings on the unit correlated with their greater willingness to attend off-unit programming because of the operation of a common motivational or personality variable. Future research using a randomized control design would clarify the actual effects of participating in these integrative groups experiences. However, the finding that many patients reported having learned valuable information about employment and training opportunities from these groups still attests to their value. In addition, the reduction in the number of self-injurious and assaultive behavioral episodes may have been an historical artifact, because the trial period coincided with a shift to greater reliance on symptom-focused pharmacotherapy on the part of unit psychiatrists. The resulting changes in patients' medications may have actually accounted for their improved behavior. Furthermore, a lengthier sampling of behavioral episodes is needed to draw more confident conclusions about the impact of these group strategies on this challenging population. However, these encouraging preliminary findings suggest the need for more rigorously controlled extensions of the current work.

In recent years, the expectations of group therapy have increased, forcing group therapists

to be more inventive. Therapists are expected to use empirically supported treatment methods, and to evaluate their effectiveness by monitoring individual patient outcomes. Effecting measurable behavioral change has supplanted providing support as the goal of treatment. Maintaining stable functioning within the institution is no longer seen as sufficient; therapists are expected to help patients develop and implement specific new skills. Escalating pressure to discharge patients more quickly has also compelled therapists to develop more effective techniques.

Today's hospitals are expected to provide care for an increasingly challenging population of inpatients, without use of seclusion or restraints. Deinstitutionalization, coupled with behavioral healthcare organizations' avoidance of costly inpatient treatment, have challenged these institutions by changing the modal characteristics of the psychiatric inpatient population they serve. As symptom severity and level of impairment have replaced diagnosis in determining patients' level of care, self injurious and other violent behaviors provide the basis for an increasing number of hospitalizations. This has resulted in a growing concentration of patients with a history of violence in many inpatient psychiatric facilities. The demand to treat these difficult clients in a short time frame, using least expensive methods, keenly challenges the creativity of those working in the public sector. The group therapy methods described in this paper provide some suggestions for ways to serve patients' needs under increasingly taxing circumstances.

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